Medically Supervised Withdrawal And Treatment - Medication Assisted Treatment

736.1 PURPOSE

To establish guidelines for participation in Medication Assisted Treatment (MAT) programs.

736.2 POLICY

Contracted facilities will participate in Medication Assisted Treatment (MAT) to the extent that the following are met: (1) the treatment is clinically appropriate for the patient; (2) the treatment is within the scope of current contractual terms; (3) the treatment is consistent with the facility's existing licensures and expertise; and (4) the treatment is consistent with local, state, and federal laws. Because of existing regulatory and licensure restrictions, some forms of Medication Assisted Treatment may not be available, at least until such time as the requisite licenses and regulatory approvals are secured or community partner identified. This policy guides participation in Medication Assisted Treatment programs in our contracted facilities. There are both opioid based and non-opioid based Medication Assisted Treatment programs. For purposes of this policy and procedure, opioid based MAT is defined as patients who are taking one of the following agents: methadone or buprenorphine-based medications. Non-opioid based MAT is defined as patients who are provided naltrexone in either oral or injectable form.

736.3 PROCEDURE

PROCEDURE FOR MAT CONTINUATION

i. Patients will be screened regarding substance use, both prescription and illicit, and substance use disorder during the Intake/Receiving Screening.

ii. Patients who are already participating in MAT programs within the community will be requested to sign a Release of Information so that more information about their medication regimen can be obtained from the community provider or previous facility. This information should include at a minimum:

   (a) Name of facility and treating provider;

   (b) Name and dose of medication obtained there;

   (c) Date of last administration;

   (d) Date of last evaluation or visit; and

   (e) Ability for a community OTP to provide the patient their medication while in the facility, if needed.

iii. Patients may also request evaluation and treatment for substance use disorder and/or substance use withdrawal directly via contact with health staff, facility staff referral, or submission of health needs request.

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iv. For those patients receiving MAT in the community, health staff will need to be provided with documentation showing the patient has been educated about the proposed MAT program and the risks and benefits of the medication regimen.

v. All patients requesting continuation of MAT while in custody will consent to and submit a Urine Drug Screen.

vi. Patients with this chronic relapsing condition of substance use disorder should be continued on verified MAT as soon as possible, consistent with Department of Justice ADA guidelines.

(a) If intake UDS is positive for other drugs besides the MAT medication, a provider should be consulted on timing of first dose of MAT while in custody and patient educated on the need for future compliance with treatment while in custody.

(b) Although the UDS should be used by the provider to assist in treatment decisions, continuation of MAT while in custody is still the preferred and accepted practice.

vii. After confirmation of community compliance with MAT, and clearance for any contraindication to its continuation, prescription orders will be written by a provider licensed to prescribe MAT:

1. Naltrexone

(a) If the patient enters the facility on naltrexone, this medication will be continued in the oral (50 mg daily) or injectable form during the patient's stay depending on availability of specific formulations at the facility, timing of patient stay, and no medical contraindication exists. Upon discharge, patients taking oral formulations of naltrexone may be transitioned to the injectable form (Vivitrol) where available.

1. The majority of patients will remain on the oral form of naltrexone while in custody.

2. Attempts will be made to transition patients to IM form upon release with coordination with community agencies as available when advance notice of release date is known.

(b) Prior to administration of a long acting injectable formulation of Naltrexone (Vivitrol). the patient must be scheduled for a naltrexone challenge:

1. Collect Urine Drug Screen (UDS) immediately prior to administration of the oral Naltrexone.

2. If UDS is positive for any opioids, then cancel Naltrexone challenge and have the patient seen by a provider to discuss the UDS result.

3. If UDS is negative for opioids, then Naltrexone 25 or 50mg by mouth can be administered.

4. Patient is observed for 90 minutes to ensure no allergic reaction or precipitation of withdrawal.

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5. If no reaction, then patient can receive the long acting injectable form of Naltrexone (Vivitrol).

6. UDS must be repeated immediately prior to any future monthly follow up injection to verify patient is not using opioids while in custody.

(c) If the patient is to receive the extended release injectable version of Naltrexone while in custody, the community entity involved, will need to obtain this medication in their provider's name and have it brought to the facility for administration to the patient.

(d) Health staff will need notification at least 72 hours in advance of the patient's release in order to have time to obtain the injection from the community entity or order via pharmaceutical company sample product programs, where available, and set up an administration time.

(e) The community entity will need to communicate with health staff the date of the patient's first appointment for community MAT care to be continued.

(f) Upon receipt of the injectable medication, the patient will be scheduled for administration of the extended-release Naltrexone preferable no more than 24-48 hours before release.

(g) The patient will be injected with the medication using the proper medical procedure above for extended release Naltrexone and monitored for 10 minutes post-injection.

2. Buprenorphine-based medications

(a) If a patient enters the facility on a buprenorphine-based medication (oral or injectable), it or an equivalent form will be continued once verified by their pharmacy, and no contraindications are determined to be present by health staff.

1. The majority of injectable forms will be converted to oral formulations while in custody.

(b) Orders may be obtained from DEA licensed staff and/or contracted employees.

(c) Initial order will be for 30 days and administered as a once daily dose as clinically indicated.

1. BID and TID dosing is discouraged as this adds to nursing medication administration duties with no change in efficacy to the patient for doses of 16 mg or less in non- pregnant patients.

2. Verified dosages from the community will not exceed 24mg daily with split dosing above 16mg only if clinically indicated.

3. Dosages will be determined by the prescribing provider after assessment of the patient not to exceed the recommended guidelines.

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(a) Doses for onsite inductions above 16mg daily should be discussed with the provider supervisor for approval and also split BID as clinically indicated.

(a) Buprenorphine-based medication administration will follow facility procedures.

(b) Buprenorphine-based medication may be crushed prior to sublingual administration.

(a) Studies show little to no change in efficacy with crushed dosing of buprenorphine.

1. Buprenorphine-based medications cannot be floated.

(b) Facilities may choose to crush all drugs associated with diversion. If this applies, then site specific policy should address it.

(c) If crush orders are individualized secondary to history of diversion with other medications, and not across the board crush orders or all patients, then documentation is required in that patient's chart supporting the individual crush order

Methadone

1. Patients entering the facility on methadone will be evaluated by medical staff and a determination made based on clinical factors to decide if they remain on methadone during their stay with courtesy dosing from the outside community OTP prescriber (or in-house if the facility has OTP licensure); If they are converted to oral buprenorphine-based medication during the stay; Or how they are to be managed through medically supervised withdrawal.

   (a) Patients not continued on methadone for any reason may be referred back to a community provider upon release

2. For patients who are maintained on oral methadone, attempts will be made to acquire the medication from a community methadone clinic if the facility is not licensed as an OTP.

   (a) If no provider is available to provide methadone to the facility, then the provider will discuss other treatment options to manage withdrawal and/or maintain another type of MAT while in custody.

3. Baseline ECG's should be obtained on all patients on methadone and as clinically indicated.

   (a) If a prolonged QTc interval is observed, then the provider should discuss the result with the patient and consider whether treatment adjustments are clinically necessary.

   (b) This is to evaluate for a prolonged QT interval, a common side effect of methadone treatment.

4. Doses will be maintained as verified from the community up to 190 mg daily.

   (a) Strong consideration should be given toward lowering the dose for patients appearing to be lethargic/sedated and/or those receiving other medications with a side effect of sedation, such as antipsychotics, Diazepam, or muscle relaxants.

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(b) Patients with prolonged QTc on ECG will be reduced to a dose that resolves the ECG abnormality.

(c) Any patient verified at over 190mg daily will need to have the order reviewed by the provider supervisor for approval.

5. Patients with doses <40mg daily are likely on starting doses of methadone. For those patients consider:

    1. Placing the patient on COWS.

    2. Offffering and starting buprenorphine-based medication when clinically indicated.

        (a) Instead of taper, these patients can be allowed to titrate up to 24mg of a buprenorphine-based medication daily.

        (b) This can be done with 4mg first dose followed by 8mg the next day with possible increase to 16mg and then 24mg as clinically indicated.

        (c) All orders and dosing for buprenorphine-based medications will be conducted by health staff.

    3. One exception to the 40mg methadone cutoff would be a person that is stable on a methadone dose of less than 40mg with no titration of dose needed.

6. Patients with methadone doses 40mg or higher should be allowed to titrate up to a dose to control their withdrawal symptoms while in custody by community partner or onsite provider if the facility has OTP status.

    1. Doses less than 80mg a day are rarely maintenance doses sufficient to control patient symptoms.

    2. Patients showing signs of withdrawal needing/requesting an increased dose will be discussed with the prescribing provider.

7. If a patient has missed more than two (2) days of methadone, then the dose should be adjusted for decreased tolerance.

    (a) Dose adjustment should be approximately a 10% decrease for every day missed.

    (b) Missed doses over four (4) days should be discussed with the provider supervisor, or community provider delivering the methadone, to determine appropriate next dose.

8. Health staff will assist patients in our contracted facilities in need of initiation of MAT medication under the conditions set forth below:

9. The patient will need to have an evaluation performed by qualified health staff, either in-house or from the community, to determine if the patient qualifies for treatment. Screening questions from the RS and comprehensive detox screen, along with a urine drug screen, can all be used to assist with the diagnosis of SUD.

    1. The provider evaluating the patient for MAT services uses criteria set forth by the American Society of Addiction Medicine and is consistent with state and

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federal regulations and other accepted medical guidelines that identify whether the patient:
Meets criteria for the diagnosis of opioid dependence; and

2. Has been dependent on opioids for a minimum of one year.
3. Requirements for one year of dependence can be waived as clinically indicated for pregnant patients and for patients previously treated for opioid dependence.

10. If the patient is deemed to be an appropriate new candidate for MAT, then there should be a community entity willing to accept this patient upon release that has the ability to provide all of the requisite follow-up care plan called for by the selected MAT therapy.
11. The patient should sign releases of information to allow 2-way communication between the community entity and facility health staff when possible.
12. The patient will be given information that outlines policies and procedures, patient rights and responsibilities, and risk and benefits of MAT options available.
13. The provider and patient will form an individualized treatment plan for MAT considering all medications available to the patient at the facility.
14. Procedures for initiation of the chosen medication will follow the procedure as outlined above for MAT continuation.
15. For facilities initiating MAT, patient populations to consider for initiation of MAT include: Those with a set sentence and known release date;
    i. Those with prior history with a MAT program;
    ii. Those with prior history of opioid overdose;
    iii. Those with COWS scores triggering withdrawal medication taper; and/or
    iv. Those initiated in conjunction with drug court, parole or probation.
    v. In all cases, any facility performing new inductions should outline the admittance criteria for the MAT program in site specific policy.
    vi. For facilities without the ability to perform new inductions of opioid based MAT medications, it is highly encouraged for health staff to offer non-opioid based alternatives such as oral naltrexone to patient requesting treatment for opioid substance use disorder.
16. All patients on MAT maintenance or new inductions are admitted to their respective MAT Program admission management will be maintained in the EMR.
17. All patients on MAT should sign a MAT consent form. A consent form for MAT can be found within imported items in the EMR.
18. If a patient on opioid based MAT therapy (i.e., methadone, buprenorphine) attempts to divert medications or use other substances against their treatment plan or facility regulations, the patient may be disqualified from continuation on opioid based MAT consistent with local state regulations.

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a. This only applies to patients stable and out of the withdrawal period. Those currently suffering from withdrawal will be seen and educated on the benefits of compliance with treatment and continued on their treatment plan.

b. Protocols for medically supervised withdrawal should be instituted for the patient as clinically indicated, along with consideration of a clinically appropriate taper period to avoid acute withdrawal.

If opioid based MAT medications (i.e., methadone, buprenorphine) are discontinued for any reason, the patient may be offered non-opioid based MAT therapy (i.e., naltrexone) as clinically indicated, along with consideration for medically supervised withdrawal.
Any patient not clinically appropriate for placement on MAT will be referred for other appropriate treatment alternatives as clinically indicated.
Pregnant patients will be maintained on opioid based MAT medications at a minimum throughout the duration of their pregnancy consistent with CM 705 Medically Supervised Withdrawal and Treatment-Pregnancy Management.

All patients receiving maintenance MAT medications will be seen by a provider as clinically indicated.
Patients refusing provider visits for evaluation of drug order renewals may have their treatment plan adjusted as clinically indicated.

(a) Patients will undergo a random Urine Drug Screen approximately monthly to ensure at least eight (8) screens a year for patients on methadone. Patients on buprenorphine-based medication can be screened with a UDS quarterly.

(b) All MAT patients will be offered education on communicable diseases such as HIV and Hepatitis C and offered screening as clinically indicated.

(c) Health staff shall use information that is generally accepted in the field of prevention or treatment of substance-related disorders as clinically indicated an in accordance with local, state, and federal statutes.

References:

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